STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063016	A. BUILDING: _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT WINDSOR PLACE	2904 W 8TH COFFEYVILLE, KS 67337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named assisted living facility on 3-11-14, 3-12-14 and 3-13-14.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a) The facility reported a census of 30 residents. The sample included 3 residents. Based on observation, record review and interview for 3 (#102, #122, #134) of 3 sampled residents, the operator failed to ensure the negotiated service agreement provided a description of the services the residents will receive, identification of the provider of each service and identification of each	S3085		

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S3085	Continued From page 1	S3085		

party responsible for payment if outside resources provide a service.

Findings included:

- Record review for resident #102 revealed admission on 12-31-12 with diagnoses Hypertension, Hyperlipidemia, Chronic Obstructive Pulmonary Disease and Coronary Artery Disease.

The functional capacity screen dated 12-31-13 recorded resident required physical assistance with bathing and dressing; independent with toileting, transfers, walking/mobility and eating; and unable to perform management of medications and treatments. Usually continent of bladder. Cognition: problems with short term memory, memory/recall and decision making. Current problems/risks identified included falls/unsteadiness, impaired hearing and impaired decision-making.

The Negotiated Service Agreement (NSA) dated 12-31-13 identified services for assistance with bathing twice a week; cueing and assistance with dressing. Staff to order, administer and store all medications and treatments. List of outside providers included podiatrist, radiation services and cancer specialist. The NSA lacked identification of pharmacy provider and oxygen provider and identification of each party responsible for payment of the outside providers.

Review of physician orders revealed: 3-14-13 oxygen at 2 liters/minute per nasal cannula. Observation on 3-12-14 at 4:52 pm of resident's room revealed oxygen concentrator.

Interview on 3-12-14 at 4:52 pm with

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S3085	Continued From page 2 administrative staff A confirmed the outside provider list is part of the NSA; further confirmed the NSA lacked identification of provider of pharmacy services, oxygen services and each party responsible for payment of the outside providers. For resident #102, the operator failed to ensure the negotiated service agreement provided identification of the pharmacy and oxygen providers; and identification of each party responsible for payment of the pharmacy and oxygen provider. - Record review for resident #122 revealed admission on 3-11-14 with diagnoses Coronary Artery Disease, Depression, Congestive Heart Failure, Non-Insulin Dependent Diabetes Mellitus, Hypertension, Anemia and Neuropathy. The functional capacity screen dated 3-11-14 recorded resident independent with bathing, toileting, transfers, walking/mobility and eating; required physical assistance with dressing; and unable to perform management of medications and treatments. Occasionally incontinent of bladder. No problems with cognition. Current problems/risks identified included falls/unsteadiness. The Negotiated Service Agreement (NSA) dated 3-11-14 recorded services for assistance with dressing; facility staff to order, administer and store all medications and treatments. List of outside providers included the podiatrist. The NSA lacked identification of pharmacy provider and identification of each party responsible for payment of the pharmacy.	S3085		

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S3085	Continued From page 3 Interview on 3-12-14 at 4:40 pm with administrative nurse C confirmed the outside provider list is part of the NSA; further confirmed the NSA lacked identification of pharmacy provider and identification of each party responsible for payment of the pharmacy. For resident #122, the operator failed to ensure the negotiated service agreement provided identification of the pharmacy provider and identification of each party responsible for payment of the pharmacy. - Record review for resident #134 revealed admission on 2-7-14 with diagnoses Cirrhosis, Diabetes Mellitus and Congestive Heart Failure. The functional capacity screen dated 2-10-14 recorded resident independent with bathing, dressing, toileting, transfers, walking/mobility and eating; and unable to perform management of medications and treatments. Occasionally incontinent of bladder. No problems with cognition. Current problems/risks identified included falls/unsteadiness, impaired vision and impaired hearing. The Negotiated Service Agreement (NSA) dated 2-10-14 stated, "Facility staff to order, administer and store all medications and treatments. The NSA lacked identification of services delegated to certified medication aides to include diabetes management (CMAs to perform blood glucose monitoring and dialing of insulin Flexpen then to give to resident to self-inject insulin). The NSA further lacked identification of pharmacy provider, oxygen provider and identification of each party responsible for payment of the pharmacy and	S3085		

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S3085	Continued From page 4 oxygen providers. Review of physician orders revealed: 2-1-14 oxygen at 2 liters/minute per nasal cannula as needed. Observation on 3-12-14 at 5:00 pm of resident's room revealed oxygen concentrator. Interview with resident on 3-12-14 at 2:15 pm stated he/she uses the oxygen at night. Interview on 3-12-14 at 2:00 pm with administrative nurse C confirmed the NSA lacked identification of pharmacy provider, oxygen provider and identification of each party responsible for payment of the outside providers. For resident #134, the operator failed to ensure the negotiated service agreement provided identification of the pharmacy and oxygen providers; and identification of each party responsible for payment of the pharmacy and oxygen provider and further failed to describe the services delegated to certified medication aides.	S3085		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides	S3200		

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S3200	Continued From page 5 shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 30 residents. The sample included 3 residents. Based on record review and interview for 2 (#102, #134) of 3 sampled residents whose medications are managed by the facility, the operator failed to ensure all medications and biologicals are administered to the residents in accordance with a medical care provider's written order and professional standards of practice. Findings included: - Record review for resident #102 revealed admission on 12-31-12 with diagnoses Hypertension, Hyperlipidemia, Chronic Obstructive Pulmonary Disease and Coronary Artery Disease. The functional capacity screen dated 12-31-13 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement (NSA) dated 12-31-13 stated, "Facility staff to order, administer and store all medications and treatments. Review of Medication Administration Records (MAR) for December 2013 revealed Biofreeze	S3200		

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S3200	Continued From page 6 circled as not administered at 10:00 am on 12-13-13, 12-14-13, 12-15-13, 12-16-13, 12-18-13, 12-19-13, 12-20-13, 12-21-13, 12-22-13, 12-23-13, 12-24-13, 12-25-13, 12-26-13, 12-27-13, 12-28-13, 12-29-13, 12-30-13 and 12-31-13. At 4:00 pm on 12-14-13, 12-15-13, 12-16-13, 12-17-13, 12-18-13, 12-19-13, 12-20-13, 12-21-13, 12-22-13, 12-23-13, 12-24-13, 12-25-13, 12-26-13, 12-27-13, 12-29-13, 12-30-13 and 12-31-13. At 9:00 pm on 12-18-13, 12-19-13, 12-20-13, 12-21-13, 12-22-13, 12-23-13, 12-24-13, 12-25-13, 12-26-13, 12-27-13, 12-28-13, 12-29-13, 12-30-13 and 12-31-13. Documentation by certified medication aides stated "Biofreeze unavailable." Review of MAR for January 2013 revealed Motrin 200 mg three times a day with meals circled as not administered at 9:00 am on 1-11-14, 1-12-14, 1-13-14, 1-16-14. At 12:00 pm on 1-11-14, 1-12-14, 1-13-14, 1-16-14. At 5:00 pm on 1-11-14, 1-12-14, 1-13-14. Documentation by certified medication aides stated "Motrin unavailable." Interview on 3-12-14 at 5:20 with administrative staff A and administrative nurse C confirmed the medications circled as not administered. Administrative nurse C and administrative staff A stated the resident's family member provided all over the counter medications and they had not been notified by staff that resident was out of medication and was not receiving them. Confirmed the following procedure for managing over the counter medications: Certified medication aides (CMAs) call the family when medications are getting low and ask them to bring the medications in. Medication aides are	S3200		

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S3200	Continued From page 7 supposed to notify administrative nurse C if they don't receive the medications in a timely manner and also notify administrative staff A if they continue to not receive the medications. Stated the MAR's are reviewed at the end of the month by administrative nurse B. Administrative staff A confirmed no policy and procedure in place for monitoring of MARs on a more frequent basis. Administrative staff C confirmed staff failed to document conversations with resident's family requesting medications. Administrative nurse C confirmed he/she failed to notify resident's physician that resident #102 had not received medications as ordered. Administrative staff A provided a new policy for "Medication Record Compliance Checks" which states: "At each shift change, the on-coming CMA will verify that the MAR has been completely initialed by the off-going CMA. They will both initial the MAR compliance form and this form will be turned in each shift to the managers office. Manager and/or facility nurse will monitor daily for compliance. The facility nurse will perform random checks to ensure MAR documentation is completed and that the compliance checks are performed by CMA each and every shift change." For resident #102, the operator failed to ensure all medications and biologicals were administered to the resident in accordance with a medical care provider's written order and professional standards of practice when the certified staff failed to administer the medications, document requests made to family and then , to notify administrative staff when the resident ran out of medication. Licensed staff failed to monitor medication records and notify the physician that resident had not been receiving medication as ordered.	S3200		

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S3200	Continued From page 8 - Record review for resident #134 revealed admission on 2-7-14 with diagnoses Cirrhosis, Diabetes Mellitus and Congestive Heart Failure. The functional capacity screen dated 2-10-14 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement (NSA) dated 2-10-14 stated, "Facility staff to order, administer and store all medications and treatments. Review of physician's orders dated 2-7-14 stated: Lactulose 10 gm/15 ml 60 ml by mouth three times per day. Handwritten MAR completed on admission stated Lactulose 10 gm/15ml 60 ml by mouth three times a day at 8:00 am, 12:00 pm and 6:00 pm. Computer generated MAR for February 2014 stated: Lactulose 10 gm/15 ml 60 ml by mouth four times a day at 8:00 am, 12:00 pm, 4:00 pm and 8:00 pm. Review of Medication Administration Record (MAR) for March 2014 revealed: Lactulose 10 gm/15 ml (grams/milliliter) 60 ml by mouth every 6 hours. Documentation on MAR revealed: 2-27-14 at 8:00 am Lactulose refused by resident. 2-28-14 at 4:00 pm Lactulose 60 ml resident refused related to loose stools and gastric upset per resident. 3-1-14 8:00 am resident refused Lactulose and 12:00 pm resident refused Lactulose. 3-4-14 at 12:00 pm Lactulose 1/2 dose given 30 ml per resident request due to loose stools per resident. Interview on 3-12-14 at 2:23 pm with administrative nurse C confirmed the dose ordered "should have been (given) three times a	S3200		

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S3200	Continued From page 9 day" Further confirmed the February computer generated MAR lacked a nurse's signature indicating it had been checked against the physician's orders. Interview on 3-12-14 at 5:12 pm with administrative staff A and administrative nurse C both confirmed administrative nurse C was responsible for checking the MAR against the physician orders and further confirmed the MAR lacked documentation of being checked. Administrative staff A stated the procedure is for him/her to enter the medication orders in the computer and print, put all admission paperwork in a folder along with the printed MAR and give to administrative nurse C who checks the and makes corrections as needed, then signs the MAR as "Reviewed by the supervising nurse." For resident #134, the operator failed to ensure the Lactulose was administered in accordance with the medical care providers' written order.	S3200		
S3216 SS=E	26-41-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or	S3216		

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S3216	Continued From page 10 discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(i) The facility reported a census of 30 residents. The sample included 3 residents. Based on observation and interview, for 2 (#102, #134) of 3 sampled residents, 10 non-sampled residents and 1 deceased resident, the operator failed to ensure licensed nurses and medication aides maintained records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation. Findings included: - Observation of an unlocked cabinet underneath sink inside of locked medication room on 3-11-14 at 4:55 pm accompanied by administrative nurse B and certified medication aide E, revealed: For resident #9 who died 3-2-14 the cabinet contained the following medications: Donepezil 5 mg (milligrams) filled 2-7-14 and 2-28-14, 43 tabs (tablets); Warfarin 5 mg filled 2-24-14, 5 tabs; Tamulosin 0.4 mg filled 1-30-14 and 2-28-14, 42 caps (capsules); Glimepiride 2 mg filled 2-17-14, 23 tabs;	S3216		

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S3216	Continued From page 11 Over the counter medications: Anti-diarrheal 6 tabs; Allergy Relief 25 mg approximately 200 caps; Acetaminophen 500 mg 225 caplets and Vision Formula with Lutein approximately 50 tabs. Current resident #1: Folic Acid 800 micrograms (mcg) 250 tabs. Current resident #2: Lisinopril 40 mg filled 12-9-13, 6 tabs. Current resident #3: Olanzapine 2.5 mg filled 2-10-14, 14 tabs; Latuda 80 mg filled 2-14-14, 35 tabs; Escitalopram 10 mg filled 2-1-14, 7 tabs. Current resident #4: Ipratropium solution 14 vials filled 11-27-13; Mirtazapine 15 mg filled 12-9-13, 49 tabs. Current resident #5: Melatonin 3 mg approximately 100 tabs; Colcrys 0.6 mg filled 1-20-14, 9 tabs; Clonidine 0.1 mg filled 1-20-14, 14 tabs; Amlodipine 10 mg filled 2-21-14, 25 tabs; Ciprofloxcin 250 mg filled 3-6-14, 8 tabs. Current resident #6: Spironolactone 25 mg filled 2-14-14, 10 tabs; Spironolactone 50 mg filled 2-28-14, 46 tabs. Current resident #7: Allergy Relief 10 mg filled 12-16-13, 10 tabs. Current resident #8: SMZ/TMP DS 800/160 mg filled 2-12-14, 8 tabs; Labetalol 200 mg filled 2-17-14, 59 tabs. Current resident #10: Aspercreme 1 tube. Sample resident #102: Hydrochlorothiazide 25 mg filled 2-10-14, 23 tabs. Sample resident #134: Tramadol 50 mg, 8 tabs. Over the counter medications: Equate Ear Wax Removal solution; Women's Laxative 5 mg tabs, 17 tabs; Acetaminophen 325 mg tabs approximately 100 tabs; Allergy Relief 25 mg approximately 75 tabs. Interview on 3-11-14 at 4:55 pm with	S3216		

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S3216	Continued From page 12 administrative staff A confirmed medication destruction forms were filled out at the time medications were destroyed, until then, does not know what medications are in the cabinet or whether any medications have been removed. Confirmed unable to accurately reconcile medications. Review of facility policy and procedure revised on 3-11-14 and provided by administrative staff A for the "Discontinued Drugs" stated: "1. When an order is received to discontinue a medication, the medication will be removed from the resident's medication box and the medication card removed...remove it from the resident's medication box and complete the discontinue log. 2. Medications which are eligible to be returned to the dispensing pharmacy for credit will be logged on the Discontinued Med form and held until picked up by pharmacy courier...3. Drugs which are not eligible for pharmacy return will be removed from the resident's medication box and ,logged on the Discontinued Medication form by the certified medication aide. These drugs must be destroyed in the presence of two licensed nurses or the pharmacist." The policy lacked specific guidelines for destruction of medications and failed to identify a time frame for removal, storage and destruction of medications. The operator failed to ensure licensed nurses and medication aides maintained records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation.	S3216		